PRENATAL SCREENING REQUISITION

Center for Human Genetics Laboratory

10524 Euclid Avenue, Sixth Floor
Cleveland, OH 44106
Telephone: (216) 983-1134
FAX: (216) 983-1150

Genetics Laboratory Use Only

FAMNUM ____________________
LABNUM ____________________
AFP __________
hCG __________
UE3 __________

Billing use only

Provider No. 99997 Location Code 50-702 Diagnosis: 655.03/655.13

Date of Service: ______________________

CPT CODES

Triple Check Insurance	Triple Check Institution	Amnio-AFP Insurance
☐ 82105-1, 84702-1, 82677-1	☐ 82105-2, 84702-2, 82677-2	☐ 82105-3
		Amnio-AFP Institution
		☐ 82105-4
Quad Check Insurance	**Quad Check Institution**	**ACHE**
☐ 82105-2, 84702-2, 82677-2, 86336-2	☐ 82105-2, 84702-2, 82677-2, 86336-2	☐ 82013

Serum AFP only Insurance ☐ 82105-1
Serum AFP only Institution ☐ 82105-2

Bill To: ______Patient ______Institution ______________(Code)

PATIENT INFORMATION (Please Print)

Name: ____

Patient I.D. or Clinic No: ________________________________

Birth Date: ________/________/________

Address : ____

City: ____________________ State: ____ Zip: _________

Telephone: ____

Race: - - - NECESSARY for all Prenatal Screening - - -

☐ Caucasian ☐ Ashkenazi Jewish ☐ Hispanic ☐ Asian
☐ African American ☐ Other: ________________________

☐ Routine Prenatal Screening

(requires red or yellow top)
(gel separator tube)
(MUST check test requested below)

____Quad Check (AFP/UE_3/hCG/Inhibin A)
____Triple Check (AFP/UE_3/hCG)
____AFP Only
____Repeat Test At This Laboratory

☐ Cystic Fibrosis Screening

(requires purple top EDTA tube)
(MUST check appropriate history)

____Patient/Couple is Pregnant
____Family History of CF
____Abnormal Ultrasound
____Absence of vas deferens
____Other infertility

Ashkenazi Jewish Panel Screening

(requires purple top EDTA tube)

☐ Ashkenazi Jewish Panel Screening, Full Panel
(Full Panel includes all below listed tests)

DOES NOT INCLUDE CF SCREENING, must be ordered separately
← Requires an additional purple top EDTA tube (see box to left)

Individual Ashkenazi Jewish Tests

○ Bloom Syndrome
○ Canavan Disease
○ Familial Dysautonomia
○ Fanconi Anemia Type C
○ Gaucher Disease Type 1
○ Mucolipidosis Type IV
○ Niemann-Pick Type A & B
○ Tay-Sachs

THE FOLLOWING INFORMATION MUST BE PROVIDED:

Sample Type: _____Serum _____Amniotic Fluid _____Peripheral Blood EDTA (CF ONLY)
(check all that apply)

Date Drawn _______/_______/_______

Patient Current Weight ______________________

Insulin-Dependent Diabetic: _______Yes _______No

Twin Pregnancy: _______Yes _______ No _______Unknown

Gestational Age Dating: MUST complete one

Last Menstrual Period ________/________/_______

Date of Ultrasound ________/________/________

-- Gestational Age on that date: ____________

EDC (by US dating only) _______/_______/_______

By Physical Exam: ____________________Weeks

-- Date of Exam: ________/________/________

PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE INFORMATION WITH THIS SPECIMEN!

REASON FOR REFERRAL

Serum

___ Routine Prenatal Screen
___ Elevated Serum AFP First Sample
___ Previous Child with Neural Tube Defect
___ Family History of Neural Tube Defect
___ Other (specify) ________________________

Amniotic Fluid

___ Maternal Age
___ Elevated Maternal Serum AFP
___ Abnormal Prenatal Screen
___ Risk for Down Syndrome
___ Risk for Trisomy 18
___ Previous Child with Neural Tube Defect
___ Abnormal Ultrasound (specify) ____________
___ Other (specify) ________________________

Referring Physician / Practice

Last Name ____________ First Name ____________
No. ____________ Street ____________
City ____________ State ______ Zip ______
Phone No. ________________________
Fax No. ________________________

Referring Center

Name ________________________
No. ____________ Street ____________
City ____________ State ______ Zip ______
Phone No. ________________________
Fax No. ________________________